BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: Mukesh Misra, M.D. Physician's and Surgeon's License No. A95774 Respondent	Case No. 800-2017-033333

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on March 10, 2021.

IT IS SO ORDERED: February 8, 2021.

MEDICAL BOARD OF CALIFORNIA

By: Richard E. Thorp MD

Richard E. Thorp, M.D., Chair
Panel B

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
REBECCA L. SMITH
Deputy Attorney General
State Bar No. 179733
California Department of Justice
300 South Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6475
Facsimile: (916) 731-2117
Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: MUKESH MISRA, M.D. P.O. Box 6711 Lancaster, CA 93539-6711 Physician's and Surgeon's Certificate No. A 95774, Respondent.	Case No. 800-2017-033333 OAH No. 2020050790 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. William Prasifka ("Complainant") is the Executive Director of the Medical Board of California ("Board"). He brought this action solely in his official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Rebecca L. Smith, Deputy Attorney General.

2. Respondent Mukesh Misra, M.D. ("Respondent") is represented in this proceeding by attorney Peter G. Bertling, whose address is 15 West Carrillo Street, Suite 100, Santa Barbara, California 93101.

3. On or about June 1, 2006, the Board issued Physician's and Surgeon's Certificate No. A 95774 to Respondent. That license in full force and effect at all times relevant to the charges brought in Accusation No. 800-2017-033333, and will expire on January 31, 2022, unless renewed.

JURISDICTION

4. Accusation No. 800-2017-033333 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on April 14, 2020. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2017-033333 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2017-033333. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2017-033333, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. Respondent agrees that, at a hearing, Complainant could establish a prima facie case or factual basis for the charges in the Accusation, and that Respondent hereby gives up his right to contest those charges.

11. Respondent does not contest that, at an administrative hearing, Complainant could establish a prima facie case with respect to the charges and allegations in Accusation No. 800-2017-033333, and that he has thereby subjected his Physician's and Surgeon's Certificate, No. A 95774 to disciplinary action.

12. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

13. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

14. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in Accusation No. 800-2017-033333 shall be deemed true, correct and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

///

///

15. The parties understand and agree that Portable Document Format ("PDF") and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

16. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or opportunity to be heard by the Respondent, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 95774 issued to Respondent MUKESH MISRA, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years to run consecutively from the conclusion of Respondent's probation term in the Board's Decision in Case No. 800-2017-033193, for a total of ten (10) years' probation, with the following terms and conditions:

1. EDUCATION COURSE. Within sixty (60) calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than forty (40) hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for sixty-five (65) hours of CME of which forty (40) hours were in satisfaction of this condition.

2. MEDICAL RECORD KEEPING COURSE – Condition Satisfied. Within sixty (60) calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment.

Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education ("CME") requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than fifteen (15) calendar days after successfully completing the course, or not later than fifteen (15) calendar days after the effective date of the Decision, whichever is later.

3. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within sixty (60) calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations ("CCR") section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education ("CME") requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than fifteen (15) calendar days after successfully completing the program or not

later than fifteen (15) calendar days after the effective date of the Decision, whichever is later.

4. CLINICAL COMPETENCE ASSESSMENT PROGRAM – Condition Satisfied. Within sixty (60) calendar days of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of three (3) and no more than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to the Board or its designee which unequivocally states whether Respondent has demonstrated the ability to practice safely and independently. Based on Respondent's performance on the clinical competence assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition or psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with the program's recommendations.

Determination as to whether Respondent successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, Respondent shall receive a

notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If Respondent did not successfully complete the clinical competence assessment program, Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

5. MONITORING - PRACTICE. Within thirty (30) calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties ("ABMS") certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision and Accusation, and a proposed monitoring plan. Within fifteen (15) calendar days of receipt of the Decision, Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and Accusation, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within sixty (60) calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within sixty (60) calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within ten (10) calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within five (5) calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within fifteen (15) calendar days. If Respondent fails to obtain approval of a replacement monitor within sixty (60) calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

6. COMMUNITY SERVICE - FREE NONMEDICAL SERVICES. Within sixty (60) calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval a community service plan in which Respondent shall, within the first two (2) years of probation, provide twenty (20) hours of free nonmedical services to a community

or non-profit organization. If the term of probation is designated for 2 years or less, the community service hours must be completed not later than 6 months prior to the completion of probation.

Prior to engaging in any community service, Respondent shall provide a true copy of the Decision(s) to the chief of staff, director, office manager, program manager, officer, or the chief executive officer at every community or non-profit organization where Respondent provides community service and shall submit proof of compliance to the Board or its designee within fifteen (15) calendar days. This condition shall also apply to any change(s) in community service.

Community service performed prior to the effective date of the Decision shall not be accepted in fulfillment of this condition.

7. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

8. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

9. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

10. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than ten (10) calendar days after the end of the preceding quarter.

11. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing thirty (30) calendar days prior to the dates of departure and return.

12. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

13. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within fifteen (15) calendar days of any periods of non-practice lasting more than 30 calendar days and within fifteen (15) calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least forty (40) hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds eighteen (18) calendar months, Respondent shall successfully complete the Federation of State Medical Boards' Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

///

14. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than one hundred twenty (120) calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

15. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

16. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within fifteen (15) calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

17. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

///

///

18. PETITION FOR EARLY TERMINATION OF PROBATION. Respondent shall not petition for early termination of probation for at least two (2) years from the effective date of this Decision.

19. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2017-033333 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Peter G. Bertling. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 11-5-20

MUKESH MISRA, M.D.
Respondent

I have read and fully discussed with Respondent Mukesh Misra, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: _____

PETER G. BERTLING
Attorney for Respondent

18. PETITION FOR EARLY TERMINATION OF PROBATION. Respondent shall not petition for early termination of probation for at least two (2) years from the effective date of this Decision.

19. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2017-033333 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Peter G. Bertling. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: _____

MUKESH MISRA, M.D.
Respondent

I have read and fully discussed with Respondent Mukesh Misra, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 11/5/2020

PETER G. BERTLING
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

DATED: 11/5/2020

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

REBECCA L. SMITH
Deputy Attorney General
Attorneys for Complainant

LA2019505318
63723061.docx

Exhibit A

Accusation No. 800-2017-033333

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
REBECCA L. SMITH
Deputy Attorney General
State Bar No. 179733
California Department of Justice
300 South Spring Street, Suite 1702
Los Angeles, California 90013
Telephone: (213) 269-6475
Facsimile: (916) 731-2117
Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: MUKESH MISRA, M.D. P.O. Box 6711 Lancaster, CA 93539-6711 Physician's and Surgeon's Certificate No. A 95774, Respondent.	Case No. 800-2017-033333 **A C C U S A T I O N**

PARTIES

1. Christine J. Lally ("Complainant") brings this Accusation solely in her official capacity as the Interim Executive Director of the Medical Board of California, Department of Consumer Affairs ("Board").

2. On or about June 1, 2006, the Medical Board issued Physician's and Surgeon's Certificate Number A 95774 to Mukesh Misra, M.D. ("Respondent"). That license was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2022, unless renewed.

///

///

JURISDICTION

3. This Accusation is brought before the Board under the authority of the following provisions of the California Business and Professions Code ("Code") unless otherwise indicated.

4. Section 2004 of the Code states:

The board shall have the responsibility for the following:

(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

(b) The administration and hearing of disciplinary actions.

(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

(f) Approving undergraduate and graduate medical education programs.

(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

(h) Issuing licenses and certificates under the board's jurisdiction.

(i) Administering the board's continuing medical education program.

5. Section 2227 of the Code states:

(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

(1) Have his or her license revoked upon order of the board.

(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

6. Section 2234 of the Code, states:

The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct which would have warranted the denial of a certificate.

(g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

7. Section 2266 of the Code states:

The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

///

///

FACTUAL ALLEGATIONS

Patient 1

8. Patient 1,[1] a then 43-year-old female, was initially referred to Respondent, a neurosurgeon, for complaints of low back pain, neck pain and headaches. On December 28, 2011, Respondent first saw Patient 1 in consultation. He noted that she complained of low back pain for almost two years with neck pain and headaches worsening in the last few months. She also complained of bilateral tingling numbness in the upper extremity, left more than right. She denied any bowel or bladder symptoms. The patient had undergone an MRI of the lumbosacral spine which showed multiple level lumbar disc disease with some disc disease in the thoracic spine, with worse disease at L3-L4 with Modic changes[2] at L3-L4 level. Following an examination, Respondent discussed the MRI findings with the patient and recommended an MRI of her cervical spine and brain in light of her complaints of pain in the neck along with headaches. He prescribed pain medications and muscle relaxants. He also recommended that she continue with physical therapy and undergo a lumbar facet block for her ongoing lower back problem.

9. On December 30, 2011, Respondent performed bilateral L3-L4, L4-L5 and L5-S1 facet injections at Antelope Valley Hospital without complications. Patient 1's pre and post procedure diagnoses were lumbar degenerative disc disease and lumbar radiculopathy. No reference was made to the presence of any bowel or bladder symptoms.

10. On January 9, 2012, Patient 1 underwent an unremarkable MRI of the brain. That same day, she underwent an MRI of the cervical spine which revealed mild degenerative changes without central canal stenosis.

11. On March 22, 2012, Patient 1 was seen by Respondent who noted that the MRI of the lumbosacral spine revealed disc disease in the lumbar and sacral area predominantly at L3-L4 and L4-L5 levels. Patient 1 reported that the previously administered facet blocks provided limited relief and then her pain would return. She denied any change in bowel or bladder symptoms.

---

[1] For privacy purposes, the patients in this Accusation are referred to as Patients 1 and 2.

[2] Modic changes is the name given to pathological changes that are present in the bones of the spine and vertebrae.

Respondent noted that his examination of the patient was unchanged. He recommended physical therapy, pain medications, muscle relaxants and another lumbar epidural/facet block.

12. During the timeframe of 2012 through August 2013, Patient 1 continued to undergo physical therapy, pain management and facet block injections for her long standing low back pain without improvement. MRI studies revealed progression of listhesis and degeneration at L3-4. On July 24, 2013, Respondent recommended an L3-L4 fusion procedure with the placement of an interspinous fusion devise given the failed conservative treatment.

13. On August 10, 2013, Respondent performed facet injections on the patient and, at that time, noted that the patient had urinary stress incontinence.

14. Patient 1 was seen by Dr. K.M. at Garrison Family Medical Group on September 3, 2013, for surgical clearance. At that time, the patient denied any bladder or urinary symptoms. Upon completion of a physical examination and diagnostic testing, Dr. K.M. was of the opinion that the patient was at low risk for surgical procedures.

15. On September 8, 2013, Respondent dictated a History and Physical Report that reflected that Patient 1 had ongoing lower back problems with worsening discogenic disease and worsening of symptoms in the recent months. Respondent noted that Patient 1 had low back pain and leg pain with radicular symptoms, left more than right. He further noted that she had "occasional urinary symptoms in the form of urine incontinence." Respondent planned to perform an elective lumbar L3-L4 posterior transforaminal lumbar discectomy, decompression, fusion and interspinous device placement.

16. On September 10, 2013, Respondent performed a posterior left L3-L4 hemilaminectomy, medial facetectomy, foraminotomy and osteotomy, left L3-L4 discectomy, transforaminal interbody fusion and decompression at L3-L4, interspinous device placement.

17. Respondent prepared an Operative Report for the September 10, 2013 procedure. There are two versions of Respondent's Operative Report for the September 10, 2013 procedure. One version is maintained as part of Patient 1's medical records at Respondent's office

///

///

("Respondent's version"). The other version is maintained as part of Patient 1's medical records at Antelope Valley Hospital ("hospital's version").[3]

18. Both versions of the Operative Report set for the following pre and post-operative diagnoses: (1) discogenic lumbar disc disease; (2) lumbar radiculopathy; and, (3) back pain.

a. The hospital version of the report has the additional pre and post-operative diagnosis of urinary incontinence.

19. Both versions of the Operative Report set forth that the following operation took place: (1) posterior left L3-4 hemilaminectomy, medial facetectomy, foraminotomy, and osteotomy; (2) left L3-4 microdiscectomy; (3) transforaminal interbody fusion and decompression at L3-4 using Axis AnyPlus TPLIF cage, Actifuse and Bacerin; (4) interspinous device placement from Axle Spine; (5) intraoperative neurophysiological monitoring and interpretation; (6) intraoperative fluoroscopy and interpretation; (7) intraoperative use of surgical microscope; and (8) placement of Jackson-Pratt drain.

a. The hospital version of the report has the additional operation included: duraform and duraseal duraplasty.

20. Both versions of the Operative Report set forth the following findings: "(1) the patient had very hard discs and soft endplates and (2) there was improvement in neurophysiological monitoring following decompression and fusion. There was no neurophysiological disturbances during surgery."

a. Respondent's version of the Operative Report sets forth the following third finding: "[t]here was a small break in the cage, hence the rest of the disc space was packed with Bacerin and Actifuse.

b. The hospital version of the Operative Report sets forth the following third finding: "[t]here was no complication during surgery."

///

[3] Both versions of the Operative Report have the same dictation identification number 5125/2775077 and reflect that the dictation was performed on September 10, 2013 at 2:49 p.m. and transcription was performed on September 11, 2013 at 9:44 a.m. The hospital version of the Operative Report reflects that Respondent authenticated and edited the report on September 11, 2013 at 9:57 p.m. Respondent's version reflects a previous print history of September 12, 2013 at 7:53 a.m.

21. Both versions of the Operative Report set forth the following indications for surgery: "The patient is a 44-year-old patient who was been having ongoing low back pain and leg pain for some time. The patient has failed conservative treatment over the last few years' time. The patient was recently admitted with bowel and bladder symptoms and lower extremity weakness, difficulty moving the lower extremities and tingling and numbness in the lower extremities. The patient had failed conservative treatment and was scheduled for the above surgery."

a. The hospital version of the Operative Report sets forth an additional indication that the "patient has had urinary incontinence in recent months."

22. Both versions of the Operative Report set forth essentially the same description of the procedure noting: "there was a very small amount of spinal fluid leak that was seen in the operative site. There was no frank CSF leak seen at any time; however since there was the suggestion of spinal fluid leak, a small amount of Duragen as well as Bioglue were placed along the operative site to prevent further spinal leak."

a. The hospital version has the additional note that "laminectomy and facetectomy was only done on the left L3 and L4 level."

b. Respondent's version also sets forth "[t]here was a small cage, which was attached to the applicator, which was <___> put in."

23. Following surgery, the patient awoke with immediate postoperative loss of neurological function in the lower extremities which correlated distally and to the instrumented levels. A post-operative MRI of the lumbar spine revealed evidence of thecal sac effacement related to what may be a combination of post-operative hemorrhage, duraseal, fluid and air. In addition, it was noted that there was a small amount of epidural hemorrhage in the ventral epidural space extending along the posterior aspect of L3 down to the L4-5 disc level which caused some degree of thecal sac effacement and that there was interval increase in disc height at L3-L4 related to anterior fusion and interbody spacer. A post-operative CT scan of the lumbar spine revealed evidence of extensive ventral and left posterolateral epidural air and debris as well as scattered epidural air extending to the T12-L1 level and below to the mid/lower L4 level. It

///

was also noted that there was a small amount of epidural hemorrhage seen at L3 and L4 primarily causing thecal sac effacement.

24. Patient 1 returned to the operating room on September 11, 2013 at which time Respondent performed a revision procedure with additional right-sided decompression and removal of the interspinous fusion device, placement of lumbar spinal drain to address cerebrospinal fluid ("CSF") fistula. Respondent noted that "there was no major compressive pathology encountered at the nerve root level or at the epidural space posteriorly and minimal lateral postoperative changes on the left side. There was improvement in neurophysiological monitoring towards the end of decompression..." The patient had electrodes for intraoperative neurophysiologic monitoring. The patient was evaluated at the time of induction... There was improvement in neurophysiological monitoring following decompression. There was a mild amount of CSF leak from the anterior lumbar region, anterior part of the thecal sac at the L3-4 level."

25. Postoperatively, the patient continued to be densely weak in the bilateral lower extremities. She underwent extensive rehabilitation therapy, including two additional revision spine procedures at Cedars Sinai Medical Center which led to two additional general surgical procedures to repair sequelae from the lateral exposure. Although Patient 1's weakness improved over the years, Patient 1 was unable to regain the ability to ambulate independently.

Patient 2

26. Patient 2, a then 46-year-old female, was initially referred to Respondent on March 15, 2012, for complaints of low back and leg pain. Patient 2 was noted to have hypertension, migraine headaches, and chronic opioid use. She had a normal body mass index of approximately 24. She had a history of a normal stress electrocardiogram and normal neurological examination secondary to migraines in December 2011. An MRI of the lumbar spine performed on March 10, 2012 revealed moderate discogenic disease at L4-L5 with a broad based central disc extrusion that migrates along the posterior aspect of L5, resulting in moderate central stenosis and bilateral lateral recess narrowing. Respondent recommended conservative management of her mild-to-

///

moderate multiple level cervical and lumbar disc disease with physical therapy, pain medication, muscle relaxants as well as cervical and lumbar epidural/facet block.

27. From 2012 to 2014, Patient 2 was seen by Respondent and recommendations were made for conservative management and treatment of her back pain, including pain medications and facet injections. During this time, repeat imaging documented a progression of radiographic findings at the L4-L5 segment and Patient 2 was symptomatic with multiple visits to the local hospital emergency departments. During this time, Respondent also performed a lumbar microdiscectomy and decompression at L4-L5 on the right side on September 4, 2012, and an anterior cervical discectomy, decompression, and fusion at C5-C6 and C6-C7 levels on April 16, 2013, to address Patient 2's ongoing lumbar and cervical issues.

28. On April 3, 2014, Patient 2 reported to Respondent that she pulled her back and heard a pop and developed severe low back and left leg pain, with pain and numbness radiating down the left leg. Her follow up MRI showed herniation of L4-L5 with stenosis. Respondent recommended bilateral lumbar facet block and if no improvement, a transforaminal lumbar interbody fusion at L4-L5 with L4-L5 intersinous device placement. On April 16, 2014, Patient 2 underwent bilateral lumbar facet block at L3-S1 and subsequently reported on May 1, 2014 that the block provided no relief and pain medications were not working. Respondent noted that the patient's MRI showed over 8 mm compression of the exiting nerve and spinal stenosis. Respondent recommended proceeding with a transforaminal lumbar interbody fusion L4-5 decompression.

29. On June 9, 2014, Respondent performed an elective L4-L5 discectomy and interbody fusion procedure to address Patient 2's lumbar radiculopathy, lower back pain and lumbar degenerative disc disease.

30. Patient 2 arrived in the operating room for the procedure at 14:06. The anesthesia start time was noted to be 14:06. Surgical preparation time was noted to be at 14:20 and surgical drape time was 14:25. Respondent's cut time of the lumbar surgery was documented to be at 14:40.

///

31. Respondent documented in the Operative Report that he obtained exposure of the L4-L5 lamina up to the facet "more onto the left side" where the patient had predominant symptoms. Respondent then noted that he confirmed adequate level of surgery and subsequently adequate placement of the hardware by plain x-ray. He further documented that scar tissue was encountered at the L4-L5 level, the discectomy was performed and interbody cage was placed into the intervertebral disc space at the L4-L5 level. He described using a shaver to instrument the L4-L5 disc space in preparation for the interbody. Thereafter, the interspinous device was placed in the interspinous region at the L4-L5 level.

32. The lateral intraoperative fluoroscopy image reflected that the 8 mm x 28 mm interbody cage was 1 mm from being flush with the anterior aspect of the L4-L5 vertebral bodies, apparently in good position. The anterior/posterior (A/P) fluoroscopic image showed the interbody in the far lateral aspect, possibly outside, of the L4-L5 disc space.[4]

33. The anesthesiology records documented a sudden drop in Patient 2's blood pressure at 15:50. The anesthesiologist, Dr. H.A., communicated the problems with the blood pressure to the surgical team.

34. Final surgical instrument count for the lumbar fusion procedure was recorded at 15:54.

35. Dr. H.A. administered five doses of phenylephrine between 15:57 to 16:07. Four doses of epinephrine were given from 16:06 to 16:22. No improvement was seen in the blood pressure and the heart rate remained in the 80s over a period of greater than 30 minutes.

36. Marcaine[5] was injected during Respondent's surgical closure at 16:25. Respondent noted that the patient tolerated the surgery very well and that there were no complications following the surgery.

37. Immediately following the lumbar fusion procedure, Patient 2 was extubated. She reported abdominal pain and the inability to move her left leg. Patient 2's abdomen became

---

[4] The A/P intraoperative fluoroscopy imaging when conjointly interpreted with the lateral images reflects that the interbody was partially outside the confines on the vertebral bodies of L4 and L5.

[5] Marcaine is an anesthetic used as a local anesthetic for a spinal block.

progressively distended and a pulse differential was noted between the two legs. Dr. H.A.'s impression was that there was a retroperitoneal bleed. Respondent obtained an emergent bedside ultrasound of the abdomen in the operating room and the diagnosis was abdominal hemorrhage. Patient 2 progressed into hypovolemic shock and cardiopulmonary arrest. Patient 2 was then reintubated.

38. Though Patient 2 remained in the operating room following the lumbar fusion procedure, at 17:00 she was noted to have returned to the operating table for a laparotomy.[6]

39. Surgical sterile preparation time for the laparotomy was documented to be 17:00. Blood transfusion was initiated at 17:15. The patient was unstable and CPR continued from approximately 17:15 to 19:05 intermittently.

40. Respondent emergently consulted thoracic and vascular surgeon, Dr. T.M., who traveled from Antelope Valley Hospital to Palmdale Regional Medical Center to consult.

41. At 17:29, Dr. T.M. performed an exploratory laparotomy at which time he identified the source of the arterial bleeding and repaired the distal abdominal aorta at the bifurcation to the right common iliac artery. Respondent assisted Dr. T.M. during the exploratory laparotomy. The laparotomy was complicated by patient instability requiring ongoing CPR outside of the surgical field and multiple retained sponges occurred.

42. Subsequently, the patient returned to surgery for the removal of one sponge. After an additional retained sponge was identified, Dr. T.M. made the decision to not intervene.

43. Patient 2 was transferred to the Intensive Care Unit in critical condition. She progressed to multisystem organ failure. Respondent consulted with Patient 2's family and the family decided to have the patient removed form life support. Patient 2 expired on June 10, 2014.

44. An autopsy revealed that Patient 2's death was a result of complications of a ruptured distal abdominal aorta/right common iliac artery with subsequent hemoperitoneum and disseminated intravascular coagulation.

///

[6] Following the lumbar procedure, the patient had been transferred from the operating table to a hospital bed in anticipation of transfer to the recovery room.

STANDARD OF CARE

45. When a neurosurgeon performs elective spine surgery of the lumbar spine and problems are identified intra-operatively, the standard of care requires that the surgeon completely explore the surgical site and treat the problem in order to optimize the patient's surgical outcome and prevent further primary injury.

46. When a neurosurgeon performs elective spine surgery of the lumbar spine, the standard of care requires that the surgeon take due precaution at all times during the surgical procedure to prevent vascular injury. In the case of instrumentation of the lumbar disc space, biplanar fluoroscopic imaging or stereotactic navigation should be used to confirm that the surgeon is operating within the confines of the disc space to prevent excursion into the abdominal cavity.

47. During the course of an elective lumbar spinal surgery, the standard of care requires that the neurosurgeon be aware of the patient's hemodynamic status at all times.

48. When triaging a patient in acute hypovolemic shock during the end of an elective lumbar spinal surgery involving instrumentation of the lumbar disc space with distention of the abdomen, the standard of care requires that the neurosurgeon immediately proceed with any and all life-saving emergency interventions to preserve life, including an exploratory laparotomy.

49. In maintaining adequate and accurate records relating to surgical procedures performed, the standard of care requires that the surgeon include information in the operative report that is essential to understanding the events of the case and the outcome, including a detailed description of any unusual circumstances encountered during the procedure.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence as to Patients 1 and 2)

50. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code in that he committed gross negligence with respect to his care and treatment of Patients 1 and 2. Complainant refers to and, by this reference, incorporates herein, paragraphs 8 through 49, above, as though fully set forth herein. The circumstances are as follows:

///

51. At the time of Patient 1's September 10, 2013 surgery, Respondent became aware that there was CSF in the surgical field, concluded that there was a dural breach and treated it with a dural augmentation onlay graft and fibrinthrombin glue. Respondent failed to explore the etiology of the CSF leak.

52. At the time of Patient 1's September 10, 2013 surgery, Respondent noted that there was a fracture of the interbody cage during implantation but failed to consider possibly removing the fractured instrumentation and inspecting the surgical tract of the implantation for injury to the proximal neural structures.

53. Respondent failed to accurately and adequately document Patient 1's surgical procedure by withholding important information regarding the fractured lumbar cage from the hospital version of his Operative Report and by stating in the hospital version of his Operative Report that there were no complications during surgery.

54. At the time of Patient 2's June 9, 2014 surgery, Respondent failed to recognize that the A/P and lateral fluoroscopic images suggested a far-lateral and potentially dangerous location of the instrumentation with intrusion into a zone of abdominal intrusion and potential vascular injury.

55. Prior to the closing of Patient 2's June 9, 2014 surgery, Respondent failed to recognize that she was hemodynamically unstable over an approximately 30-minute period and failed to consider a possible vascular injury from the laterally placed interbody.

56. In his Operative Report for Patient 2's June 9, 2014 surgery, Respondent failed to fully describe the events that led to the patient's arterial injury.

57. Respondent's acts and/or omissions as set forth in paragraphs 8 through 56, above, whether proven individually, jointly, or in any combination thereof, constitute gross negligence pursuant to section 2234, subdivision (b), of the Code. Therefore, cause for discipline exists.

///

///

///

///

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts as to Patients 1 and 2)

58. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code in that he committed repeated negligent acts with respect to his care and treatment of Patients 1 and 2. Complainant refers to and, by this reference, incorporates herein, paragraphs 8 through 56, above, as though fully set forth herein. The circumstances are as follows:

59. At the time of Patient 1's September 10, 2013 surgery, Respondent became aware that there was CSF in the surgical field, concluded that there was a dural breach and treated it with a dural augmentation onlay graft and fibrinthrombin glue. Respondent failed to explore the etiology of the CSF leak.

60. At the time of Patient 1's September 10, 2013 surgery, Respondent noted that there was a fracture of the interbody cage during implantation but failed to consider possibly removing the fractured instrumentation and inspecting the surgical tract of the implantation for injury to the proximal neural structures.

61. Respondent failed to accurately and adequately document the surgical procedure he performed by withholding important information regarding the fractured lumbar cage from the hospital version of his Operative Report and by stating in the hospital version of his Operative Report that there were no complications during surgery.

62. At the time of Patient 2's June 9, 2014 surgery, Respondent failed to recognize that the A/P and lateral fluoroscopic images suggested a far-lateral and potentially dangerous location of the instrumentation with intrusion into a zone of abdominal intrusion and potential vascular injury.

63. Prior to the closing of Patient 2's June 9, 2014 surgery, Respondent failed to recognize that she was hemodynamically unstable over an approximately 30-minute period and failed to consider a possible vascular injury from the laterally placed interbody.

64. In his Operative Report for Patient 2's June 9, 2014 surgery, Respondent failed to fully describe the events that led to the patient's arterial injury.

///

65. Respondent failed to appropriately intervene and address Patient 2's deteriorating condition following the June 9, 2014 procedure by failing to immediately proceed with an emergent laparotomy to attempt to manually control Patient 2's exsanguination while waiting for the vascular consult to arrive.

66. Respondent's acts and/or omissions as set forth in paragraphs 8 through 65, above, whether proven individually, jointly, or in any combination thereof, constitute repeated negligent acts pursuant to section 2234, subdivision (c), of the Code. Therefore, cause for discipline exists.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Dishonesty as to Patient 1)

67. Respondent is subject to disciplinary action under 2234, subdivision (e), of the Code, in that he committed unprofessional conduct, involving dishonesty or corruption, when he included different and varying information in the two operative reports for Patient 1's September 10, 2013 procedure. Complainant refers to and, by this reference, incorporates herein, paragraphs 17 through 23, above, as though fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records as to Patients 1 and 2)

68. Respondent's license is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate and accurate records concerning the care and treatment of Patients 1 and 2. Complainant refers to and, by this reference, incorporates Paragraphs 17 through 23, 29 through 36, 49, 53, 56, 61, and 64, above, as though set forth fully herein.

DISCIPLINARY CONSIDERATIONS

69. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on January 23, 2020, in a prior disciplinary action entitled *In the Matter of the Accusation Against Mukesh Misra, M.D.* before the Medical Board of California, in Case Number 800-2017-033193, Respondent's license was revoked for gross negligence and repeated negligent acts in the care and treatment of one patient. However, the revocation of Respondent's license was stayed and Respondent was placed on probation for two (2) years to run consecutively from the conclusion of Respondent's probation term in the Board's Decision in

Case No. 800-2014-005853, for a total of five (5) years' probation with the requirement to complete an education course, medical record keeping course, Clinical Training Program, maintain a practice monitor and other standard terms and conditions. That decision is now final and is incorporated by reference as if fully set forth herein.

70. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on May 3, 2018, in a prior disciplinary action entitled *In the Matter of the Accusation Against Mukesh Misra, M.D.* before the Medical Board of California, in Case Number 800-2014-005853, Respondent's license was revoked for gross negligence and repeated negligent acts in the care and treatment of one patient. However, the revocation of Respondent's license was stayed and Respondent was placed on three years of probation with the requirement to complete a Clinical Training Program, maintain a practice monitor and other standard terms and conditions. That decision is now final and is incorporated by reference as if fully set forth herein.

71. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about June 28, 2012, in a prior disciplinary action entitled *In the Matter of the Accusation Against: Mukesh Misra, M.D.*, before the Medical Board of California, Case No. 08-2007-186068, Respondent's license was disciplined and he was required to take educational courses, a medical record keeping course, and a professionalism program. Respondent successfully completed the coursework and, on or about April 26, 2016, Respondent was publicly reprimanded for failing to adequately document a surgical procedure and the post operative condition and care of the patient. That decision is now final and is incorporated by reference as if fully set forth herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 95774, issued to Mukesh Misra, M.D.;

///

2. Revoking, suspending or denying approval of Mukesh Misra, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Mukesh Misra, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: APR 14 2020

CHRISTINE J. LALLY
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

LA2019505318
Misra Accusation.docx